

RECOMMENDED PATIENT SAFETY PRACTICES – MEDICATION ERRORS

Best Practices adopted by Tennessee Improving Patient Safety (TIPS) on March 1, 2002

10 CONFUSING ABBREVIATIONS TO AVOID

The following chart shows medical abbreviations that often lead to unwanted outcomes:

Abbreviation	Intended Meaning	Common Errors
U	Units	Mistaken as a zero or a four (4) resulting in overdose. Also mistaken for “cc” (cubic centimeters) when poorly written.
ug	Micrograms	Mistaken for “mg” (milligrams) resulting in a ten-fold overdose.
Q.D.	Latin abbreviation for every day	The period after the “Q” has sometimes been mistaken for an “I,” and the drug has been given “QID” (four times daily) rather than daily.
Q.O.D.	Latin abbreviation for every other day	Misinterpreted as “QD” (daily) or “QID” (four times daily). If the “O” is poorly written, it looks like a period or “I.”
SC or SQ	Subcutaneous	Mistaken as “SL” (sublingual) when poorly written.
T I W	Three times a week	Misinterpreted as “three times a day” or “twice a week.”
D/C	Discharge; also discontinue	Patient’s medications have been prematurely discontinued when D/C, (intended to mean “discharge”) was misinterpreted as “discontinue,” because it was followed by a list of drugs.
HS	Half strength	Misinterpreted as the Latin abbreviation “HS” (hour of sleep).
cc	Cubic centimeters	Mistaken as “U” (units) when poorly written.
AU, AS, AD	Latin abbreviation for both ears; left ear; right ear	Misinterpreted as the Latin abbreviation “OU” (both eyes); “OS” (left eye); “OD” (right eye).

Resource:

Agency for Healthcare Research and Quality, <http://www.ahrq.gov/consumer/20tips.htm>